ADVANCING NURSING PRACTICE IN NEW ZEALAND: A PLACE FOR CARING AS A MORAL IMPERATIVE

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Abstract

Advanced nursing practice is now formally endorsed in New Zealand. However, the framework of competencies that nurses applying for endorsement need to demonstrate is functionally oriented. There is no recognition of the relational competencies required to practice caring as a moral imperative. This gap denies the significance of nursing as a moral practice. In this paper it is argued that a more balanced framework would give equal attention to both functional and relational competencies. A practice exemplar is used to demonstrate positive outcomes from advanced relational competencies. Also evident in the practice exemplar is the view that practising the relational competencies associated with the nursing as a caring practice discourse 'pushes the boundaries' of the dominant discourse of nursing as a functional service. This paper explores the history of these two discourses and the assumptions that underpin them. When missing from descriptions of advanced nursing practice, relational competencies are rendered invisible and peripheral, rather than central and therapeutic. In our highly technological health service the recognition of human to human connection is more important than ever.

Key Words: Competency, advanced practice, Nurse Practitioner™, moral imperative

Introduction

Formal acknowledgement of advanced nursing practice is now a reality internationally. In New Zealand the Nursing Council of New Zealand (NCNZ) is charged with the endorsement process of advanced practice. Nurse Practitioner™ (NP) is the conferred title after successful completion of endorsement. The documents, which set out this process, emphasise certain advanced functional competencies designed to be therapeutic in meeting particular client needs relating to diagnosis and treatment (NCNZ, 2001, 2002). In this article I argue that equal attention be given to the therapeutic significance of relational skills associated with caring as a moral imperative. To advance functional competencies, without the relational skills needed to genuinely attend to the humanness of people undermines the significance of nursing as a moral practice incorporating promotion of person-family-community well-being in all its many guises (Johnstone, 1999).

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Emphasis on advancement of functional competency supports the dominance of the technico-rationalistic paradigm (Cash, 2001), or what I will refer to in this discussion as the functionalist discourses. This emphasis negates the therapeutic effectiveness of relational skills, relegates their significance to the periphery and reinforces the invisibility of caring (Connor, 2002; Crowe, 2000).

The NCNZ (2001, p. 10) describes a novice nurse's ethical competency as "practises nursing in accord with values and moral principles which promote client interest and acknowledge the client's individuality, abilities and choice". In the same document and in a later report (NCNZ, 2002) advanced nursing competencies relate largely to the functionalist discourse. There is no mention of what constitutes advancing ethical or moral judgements and the relational skills in which these judgements are attained. The NP™ competency framework appears to assume that nurses in undergraduate nursing programmes have learned all that is necessary to make high level moral judgements. If this assumption is correct it is counter to the premise of moral judgement developing through reflection on expanding knowledge and experience (Benner, Tanner & Chesla, 1996; Carper, 1978)

Carper (1978), in her seminal paper of different ways of knowing in nursing, saw moral knowing as critical in advancing nursing judgement. For Carper, advanced nursing judgements are informed by the expansion of self knowledge learned from reflexive moral decision making and embrace what needs to be done for particular people in particular situations. Other ethical approaches such as quandary, principle-oriented and/or procedural ethics are used to determine the 'right approach' when an ethical dilemma is present (Benner, et al., 1996; Cooper, 1991). Procedural ethics does not deliberate on what is 'good' within people's lives. Practising caring as a moral imperative involves the deliberation of what is 'good and right' for people in need of nursing on a day to day basis. The caring discourse in nursing is much more than nurses conveying a caring attitude while performing functional work (Street, 1991).

The contours of what is 'right' and 'good' are socially constructed in a pluralistic world and are therefore often in transition. They differ between generations, religions, cultures and communities. What is determined as 'good' for people can only be arrived at within a dialogue with them. The contemporary dilemma of what is now technically possible to improve health but fiscally rationed and not always 'good' for the recipients can increase the complexity of moral good (Pellegrino & Thomasma, 1988; Thorne, 1993). Nurses' perspectives of right and good are an important part of the dialogue but should not dominate. Dialogue requires tolerance of difference and implies movement in the views of all participants. This process often necessitates the walking of a fine line between openness and compromise of personal integrity. Closure of relationships, rather than a breach of

personal integrity, may sometimes be the best option. The complexity of entering into the moral territory of others and working with them to obtain a good outcome necessitates advanced nursing knowledge and experience. As such the relational competencies inherent in such work need be part of the explicit framework of NP™ practice.

The following is a nursing exemplar from my research that demonstrates the effectiveness of practising caring as a moral imperative (Connor, 2002).

Exemplar from practice situation

Sarah, a middle aged woman, lived with a chronic respiratory illness from childhood. The experience of childhood illness left Sarah with a sense that her 'whole being' was affected and a feeling of inferiority in relation to her peers. Sarah's situation is what Pellegrino and Thomasma (1988) call the ontological assault of illness. A series of acute disease episodes during her young adulthood compounded her feelings of difference. Failure by health professionals operating within a disease oriented system to assess her vulnerability and suffering and address this ontological assault led to an impasse in Sarah's care.

A time of severe strife developed when Sarah spent approximately 20 weeks in each of two years in an acute medical ward. Much of this period was perceived as a de-moralising struggle as highlighted in the expressions, 'a freak' 'caged in' 'a wild animal', used when she talked about this period. Consequences of the de-moralisation included a major loss of confidence in managing her condition at home and strong sense of feeling unsafe outside of hospital. At the end of the two years the community nursing response was changed to attend to how Sarah perceived her world rather than focusing on her disease symptoms. Her experience of the world included feelings of stuckness, much hurt and anger and great fear, which at times, overwhelmed her. Sarah interpreted the changed nursing response as 'someone there caring for me'. She perceived the outcome of the caring as a 'sharing of her illness burden'. This sharing provided space for her sense of safety in the community to increase and with it a greater confidence in managing her fluctuating symptoms, extended participation in her local community and a decrease in hospitalisations.

The nurses saw that a significant component of the 'caring' took place within what was described as an 'intense relationship', a prolonged person to person relationship in which one nurse attended to Sarah's intense feelings arising from her suffering and de-moralisation. It was a relationship that the nurses believed 'pushed the boundaries' of the nursing care usually practised within the regular community nursing service where they worked. The relationship was characterised by the navigation of many 'fine lines' which required ongoing moral judgements. These fine lines included being dependable but not encouraging dependence; walking alongside her but not being caught in the immediacy of her suffering,

thereby maintaining a reflective orientation and avoiding becoming burned out. Other aspects were knowing when to involve medical intervention and when to coach confidence in staying at home; offering instrumental advice and assistance for the many discomforts Sarah experienced but not becoming judgmental if they were declined; valuing non-directiveness yet becoming directive when the situation called for it. It was necessary also to acknowledge her de-moralisation and consequent belief that suicide would be a good option for her while at the same time promoting hope in future possibilities. Increasing attention had to be balanced against withdrawing attention, as did practising autonomously and being member of a team. In short it was a fine line between being therapeutic and non-therapeutic. The experienced and competent nurses in the research believed the navigation of relationships such as the one described above demonstrated advanced nursing practice.

Discernment of discursive influences in Sarah's care

If the caring received by Sarah pushed the boundaries of care it begged the question of what constructed boundaries were being pushed. Her situation resulted in an impasse within the boundaries of the functionalist disease discourse. It called for an expanded boundary view to include 'the ontological assault of illness'; a view which made the person/family and context central in care as in the changed approach with Sarah. Such a view can be termed the health-illness discourse; a discourse that is described in nursing, medical, philosophical and sociological literature (Benner et al., 1996; Brody, 1987; Cassell, 1991; Frank, 1995; Herzlich & Pierret, 1987; Kleinman, 1988; Litchfield, 1997; Madjar & Walton, 1999; Morse & Johnson, 1991; Newman, 1994; Parse, 1995; Pellegrino & Thomasma, 1988; Thorne, 1993; Yardley, 1997). Attention to illness as more than disease arose from the increasing phenomena of chronic illness and disability throughout the twentieth century. Some writers stress illness which co-exists with health and others stress health which can encompass illness. Hence, the term health-illness discourse. The majority of writers on the health-illness discourse express it in existential or ontological ways. They state the need for caring as a moral imperative in responding to this view of health-illness.

Critique of the nurses' experience in caring for Sarah pointed to what was seen as influences of the health reform contract environment where fiscal measurement, short admissions and fragmentation reigned. These facets form a basis for what I call the 'nursing as a functionalist service discourse' (functionalist nursing discourse). Creating an 'intense relationship' pushed the boundaries of the functionalist nursing discourse and was problematic in that it could not be enacted by a series of different nurses, even though they may appear to be interchangeable. When seen through a functionalist lens there was some doubt that such a close relationship was the province of

nursing. Nevertheless, Sarah asserted that she would not have moved out of strife without it. Practising the moral imperative of caring provided Sarah with the space she needed to reflect on the chaos of her life and find her own path forward. I call this the 'nursing as a caring practice discourse' (caring discourse). Although the world view inherent in the health-illness and caring discourses are well proclaimed, they are difficult to practise because of the deeply embedded disease and functionalist nursing discourses in most large health service organisational cultures. Unfortunately the term 'disease state management', used in the evolving Nurse Practitioner™ scopes of practice (NCNZ, 2002) reinforces the functionalist nursing discourse.

When knowledgeable and experienced nurses are confident practising in the caring discourse, justifying it by articulating the outcomes for people's health-illness circumstances, they can push the boundaries of the dominant discourses. Acknowledgement of the competencies inherent in the caring discourse by the NZNC in its endorsement of NP's™ will increase their visibility and legitimacy.

History

The sociologists Wooldridge, Skipper, and Leonard (1968), epitomise the early articulation and shaping of nursing within the behaviouralist stream of sociology and psychology. At that time social organisational concepts such as 'role', 'team', 'norm' and the 'valuing of hierarchies' were applied to different professions. Furthermore, the instrumental tasks of nursing were seen to be an adjunct of the disease discourse. Nursing practice became doubly embedded in the functionalist discourses of science. 'The Nursing Process' or what is still known as 'The Nursing Diagnosis Movement' exemplifies this situation (Bishop & Scudder, 1991). Ironically, nursing in seeking to distinguish itself from the disease discourse in order to claim its own professional ground took on a different but similar functionalist discourse. However, the advent of new socio-psychological theories challenged the dominant position of behavouralism. Interaction theories of nursing developed from these new theories (Orlando, 1961; Peplau, 1952/1988). Thus, what became recognised as the expressive thread (discourse) of nursing began to contest the dominance of the functionalist discourse.

Nurse researchers expanded the expressive discourse within the person-centred, humanistic approach (Gadow, 1980; Paterson & Zderad, 1976; Watson, 1985). In this approach the emphasis on the organisational structures of the functionalist nursing discourse became problematic. Primary nursing developed as a solution. Primary nurses would be responsible and accountable for the person-centred care of small groups of clients throughout their admission to a health service. However credible primary nursing schemes proved hard to embed in large organisational structures because of the dominance of the functionalist disease and

nursing discourses. The effects of these dominant discourses on the caring person-centred approach are well illustrated in Street's (1991) research.

Debates about caring as the essence of nursing became integral in the expansion of the person-centred nursing (Morse, Solberg, Neander, Bottoroff, & Johnson, 1990). The progression in understanding stressed relational processes linked to ethical theories rather than expressive interaction (Cooper, 1991; Fry, 1988). At the same time Bishop and Scudder (1991) gave currency to nursing as a caring practice designed to respond to the moral 'good' of people. Critique is vital to the ongoing debate (Dyson, 1997). The context of caring practice, as was the case with Sarah, will always determine the expression of caring and as such will negate any general consensus about what informs caring as a moral imperative in nursing (Warelow, 1996)

Historically then, nursing has accommodated both the functionalist nursing and caring discourses. It is now time to give equal value to the caring discourse in order to counterbalance the subtle pressures of functionalist discourse assumptions; to see the level of caring practice perceived by Sarah, not as pushing the boundaries of functionally oriented nursing, but as equally central within the orbit of nursing.

Assumptions of the caring and the functionalist discourses

Assumptions of the caring discourse along side those of the functionalist nursing discourse are set out in Table 1. The table works as a theoretical device drawing attention to difference, yet the assumptions are not mutually exclusive. As a de-construction it invites a re-construction. A re-construction takes place where there is a space to deliberate the paradoxical tension of opposites, the and/both of different assumptions. In this space is an opportunity to move beyond difference, to embrace strength while acknowledging weakness and to deepen and integrate the knowledge and wisdom of moral practice. To dwell in and make wise judgements in such a space requires the ability to live with uncertainty, paradox, and complexity. Deliberation on the assumptions that influence practice in such a space is a starting point for understanding the way dominant discourses are often presented as value-neutral (Cash, 2001) and impinge on our consciousness in many subtle ways. It is a space where high level technical and relational competencies can be refined. Therefore, identification of assumptions can assist nurses to understand the tensions and complexity produced when operating in the 'in-between' space of the discourses and experiencing the 'to and fro' pull from one to the other.

However, there is a strong human drive to favour certain assumptions which in turn decrease the ability of keeping an open gaze on the assumptions of both discourses. In these conditions making judgements about what is 'right' in particular situations can be difficult. These conditions require the confidence and

Table 1. Summary of assumptions in the nursing as a caring practice and nursing as a functionalist service (Adapted from Connor, 2002)

Areas of difference in:	Nursing as a caring practice	Nursing as a functionalist service
Ethic and ethos	Establishing the meaning of health-illness events to the person family and working towards wellbeing as discerned by them. Prepared to take time for greater understanding and greater effectiveness Being with I-thou - subjective	Responding to functional deficits. Concerned with how to get the greatest good for the greatest number within budget. Completing work within allocated time periods Doing for I-it (functional deficit) - objective
Orientation	Person-family centred Process and relational Relational competencies - use of self as central to healing environment. Continuity of practitioner important. Nurses' individual practice Usually generalist or advanced practice	Institution centred Product and Instrumental Technical competencies - Nurses with same competencies are interchangeable. Neutrality of environment Roles and teams Usually specialist
Accountability/ Authority	Accountability to client group Authority in expertise	Accountability to institution Authority invested in roles of managers and health specialists within hierarchies Protocols to follow
Effectiveness	Subjective - what it means to people: relates to personal goals fulfilled. Can be measured in changes in the way people get on with life.	Inputs and outputs Health status indicators based on rationalistic construction

skill of advancing nursing judgement to transcend the boundaries of the dominant view. Without the enacting of the caring discourse, people like Sarah experiencing the ontological assault of illness, will continue to experience impasses in their health care.

Conclusion

Frustrations can abound when nurses embrace the caring discourse in an environment shaped by the functionalist nursing discourse. The skilled relational approach can be seen as a 'nice to have extra', a waste of 'time' or the province of another discipline. The moral significance of nursing practice is minimalised; control over practice and effectiveness is undermined by organisational constraints; and people's care fragmented from the involvement of a number of different nurses with variable skills. Such frustrations often result in experienced nurses leaving their positions with the consequent loss of a skilled nursing contribution to the health of New Zealanders. Inclusion of the competencies inherent in the caring discourse in the written practice framework of the NP™ will, I believe, significantly advance the importance of this discourse in nursing. NPs™ will be visible models of caring as a moral imperative. In the contemporary world of health care, shaped by functionalist discourses, practising caring as a moral imperative in nursing is more important that ever.

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